Indian Health Service Strategic Plan:

Fiscal Years 1997-2002

January, 1998

I. Overview

The Indian Health Service (IHS) approaches the next millennium in the midst of the most profound changes in its history. It is simultaneously faced with the challenges of downsizing and restructuring our administrative infrastructure, providing for local control of resources to tribes wishing to exercise their options of self-determination, reinventing ourselves through the directives of the Reinventing Government/National Performance Review process, and demonstrating "results" consistent with the Government Performance and Results Act (GPRA). This strategic plan plots a course for the Agency to follow over the next six years in light of this changing environment. It is based heavily on efforts made over the past three years toward reorganizing the IHS under the guidance of the Indian Health Design Team (IHDT).

In October of 1994, Dr. Michael Trujillo, Director, IHS, announced his vision of a new IHS that would be the best primary care health system in the world. Viewing change as an opportunity, he outlined an approach using broad stakeholder participation for being more responsive to the changing expectations of Indian people and the realities of federal government downsizing and increasing health care costs. In early 1995, the Director charged the IHDT to develop a plan for the reorganization of the IHS. The IHDT was composed of the primary stakeholders of Indian health care: Indian people, tribal leaders, and IHS employees. Of the 29 people serving on the IHDT, 22 were tribal and/or urban Indian program representatives. In addition, input for the reorganization process was solicited by the IHDT from:

1. presentations and written recommendations from seven technical work groups composed of federal, tribal, and Urban representatives,
2. surveys of consumers needs and their expectations relative to health care,
3. surveys (written and electronic) of all IHS employees regarding concerns and suggestions for reorganization, and
4. focus group sessions for Area and Headquarters staff for discussion and suggestions relative to IHDT recommendations.

Through a series of facilitated planning sessions, the IHDT synthesized this information and reached consensus on an approach for reorganizing the IHS. The primary approach identified was to focus on efforts to support and empower the local health delivery program, whether it be IHS operated, tribally managed, or an urban Indian health program, henceforth referred to collectively as the

"I/T/U." This reorganization plan also included new **Mission, Goal**, and **Foundation** statements and a set of **Guiding Principles** which provide the basis for this Strategic Plan.

II. Mission, Goal, and Foundation of the IHS

MISSION:
The mission of the Indian Health Service, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level.

GOAL:
To assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

FOUNDATION:
To uphold the federal government s obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of tribes.

III. Guiding Principles of the IHS

PATIENT CARE COMES FIRST
The concepts of patient (i.e., individual, family, or community) and care (i.e. curative preventive, traditional, educational) are referred to in the broadest sense.

BE CUSTOMER-CENTERED
Being customer-centered shall become a core value in the mission of all Indian organizations along with the IHS. Customers include all people, tribes, and other Indian organizations dependent on a program's services.

FOCUS ON HEALTH
Clinical, public health, and administrative functions shall be focused to promote high quality and cost effective patient care services directed toward improving the health status of American Indian and Alaska Native people .

SOVEREIGNTY
The federal government shall honor, uphold, protect, and advocate inherent sovereign rights and rights of the American Indian and Alaska Native Nations as evidenced by the treaty signing process, the content of those signed treaties by the signatory parties, and as afforded by the U.S. Constitution, Treaties, U.S. Statutes, Treaty Cessions, State Constitutional Disclaimer Provisions, Agreements, International Declarations of Indigenous Peoples Rights and Executive Orders.

CULTURAL SENSITIVITY
Structure, programs, and services shall be designed in partnership to respect cultural diversity at the local level.

TRUST RESPONSIBILITY
The Federal government has the trust responsibility to provide health services to Indian people.

EMPOWERMENT/ADAPTABILITY
Sufficient decision making autonomy shall exist at the local level to enable capacity to address service delivery needs.

ACCOUNTABILITY
Accountability systems shall be designed to ensure efficiency, effectiveness, and patient and customer satisfaction regarding the achievement of IHS' primary mission involving patient care, health promotion, and advocacy for tribal governments and Indian organizations.

TREAT EMPLOYEES FAIRLY
Employees shall be treated fairly and compassionately in all changes in the structure and programs of Indian health programs.

EXCELLENCE
Commitment to excellence shall be achieved and maintained in administrative, clinical, and public health programs and practices.

SYSTEM-WIDE SIMPLIFICATION
Administrative requirements and systems shall be simple and efficient for all Indian health programs.

FULL DISCLOSURE AND CONSULTATION
The IHDT products shall be provided to stakeholders. Consultation shall be undertaken with Tribes and Indian organizations to achieve knowledgeable participation in decision making.

IV. Strategic Objectives

The following Strategic Objectives have been identified as essential for the realization of our **Mission, Goal,** and **Foundation** and supporting our **Guiding Principles** over the next six years. These broad objectives set a long-term programmatic, policy, and management course for the IHS. They are also consistent with the most recognized approach to evaluating health care organizations in that they address the *structure, process,* and *outcomes* of health care delivery and they provide the conceptual and philosophical framework for selecting performance indicators.

Strategic Objective 1: Improve Health Status

To reduce mortality and morbidity rates and enhance the quality of life for the eligible American Indian and Alaska Native population.

RATIONALE AND ASSESSMENT APPROACH

Achieving the Mission of the IHS requires improvements in health status of American Indian and Alaska Native people in the broadest sense. The most objective and valid measures for demonstrating improved health status are mortality and morbidity rates which can serve as "outcome" measures/indicators or objectives. However, it is sometimes more practical and appropriate, particularly in the short run, to measure activities or processes that have significant potential to contribute to improved health status. Activities that may be essential and at least useful but not necessarily adequate in improving health status are "process " indicators (e.g., establishing baseline assessments). "Impact" indicators represent documented reductions in risk factors of mortality and morbidity such as number of people quitting smoking, maintaining appropriate weight, or using child restraints in cars. Such reductions in risk factors have a scientifically demonstrated association with improved mortality and morbidity.

In partnership with I/T/Us, the IHS will select a combination of process, impact and outcome indicators that represent the priority health areas for the Agency as a whole. In addition, Areas and local I/T/Us may elect to select additional measures that reflect their unique priorities. The IHS will also seek collaborative partnerships with other Agencys and organizations in efforts to improve the health status and quality of life of the American Indian and Alaska Native people.

Strategic Objective 2: Provide Health Services

To assure access to high quality comprehensive public health services (i.e., clinical, preventive, community-based, educational, etc.) provided by qualified culturally sensitive health professionals with adequate support infrastructure (i.e., facilities, support staff, equipment, supplies, training, etc.)

RATIONALE AND ASSESSMENT APPROACH

Assuring the accessibility and acceptability of high quality comprehensive health services is the primary method for the IHS to improve the health status of the American Indian and Alaska Native people, and is where over 90 percent of IHS resources are directed. Many clinic based services directly reduce mortality and morbidity by intervening in injuries control and disease processes. Some services such as immunizations, or clean fluoridated water, actually represent reduction in risk factors to disease and thus are, in and of themselves, impact in nature. Other services such as

community education and well baby clinics have a less direct effect on preventing disease by empowering families and individuals to more effectively practice healthy behaviors.

Four critical elements have been selected for assessing health care: accessibility, acceptability, quality, and coverage. While it is useful for all four to be assessed by the consumer, only the consumer can adequately assess accessibility and acceptability because they only have real validity from the consumers perspective. Accessibility addresses the availability and ease of using the services while acceptability addresses the more interpersonal aspects of care such as providers respect, caring, and cultural sensitivity. Thus, consumer satisfaction data should serve as the basis for these important assessments.

Quality of health care, particularly the technical and process elements, can probably be best assessed by objective measures such as the JCAHO accreditation process and the Health Plan Employer Data and Information Set 3.0 (HEDIS 3.0) evaluation process.

Finally, with the rapidly growing American Indian and Alaska Native service population, it is necessary to continuously find ways to expand services, or health status will decline. Thus, the final critical element of health care is coverage and efficiency which is an assessment of who gets what services, and the relative costs for doing so. As with the outcome and impact indicators to be used, performance indicators from workload data will be selected in collaboration with tribes, urban programs and tribal organizations. These data elements will quantify high priority services in conjunction with cost estimates.

Strategic Objective 3: Assure Partnerships and Consultation

To assure that I/T/Us, and IHS Area and Headquarters achieve a mutually acceptable partnership in addressing health problems.:

- p*roviding adequate opportunities for I/T/Us and American Indian and Alaska Native organizations to participate in critical functions such as policy development and budget formulation*
- *assuring that I/T/Us have adequate information to make informed decisions regarding options for receiving health services*

RATIONALE AND ASSESSMENT APPROACH

Creating effective partnerships with I/T/Us and tribal organizations has become increasingly essential to the Mission and Goal of the IHS. To achieve the trust essential for this partnership and collaboration to effectively occur requires full disclosure by the IHS and a high level of I/T/U participation in the important business of the Agency. The mechanism and elements for this relationship should be specified in a formal IHS policy. The assessment of these elements can only be made from the I/T/U perspective, and thus requires a survey of all, or a sample from all, I/T/Us.

This survey should be developed with adequate tribal representation to assure the survey is valid and appropriate for evaluating these elements of IHS performance.

Strategic Objective 4: Perform Core Functions and Advocacy

*Consistent with the **IHS Mission, Goal** and **Foundation**, to effectively and efficiently:*

- *advocate for the health care needs of the American Indian and Alaska Native people*
- *execute the core public health and inherent federal functions*

RATIONALE AND ASSESSMENT APPROACH

Core functions represent essential public health and administrative functions the Agency must

continue to effectively accomplish but with a significantly downsized infrastructure. Selecting performance indicators for these functions is vital in assuring the long-term health and viability of the Agency and its Mission and Goal. Advocacy is a somewhat more abstract concept but essentially means proactively acting to raise focus (i.e., attention, awareness, interest, and hopefully support) on issues relevant to the health of American Indian and Alaska Native people. Performance indicators for advocacy can include a variety of process measures such as monitoring the number of collaborative agreements with other Agencys or organizations to enhance health services, and documentation and reporting to Congress of identified and emerging health problems in the service population.

Assessment of the Agency s efficiency in meeting core functions can be assessed by monitoring the percentage of the IHS budget directed at these administrative functions. Thus, the goal will be to maintain these functions at an adequate level, based on our compliance with Federal requirements, while attempting to reduce the size of the Agency s administrative overhead. This reprogramming of resources to support enhanced health services is a directive of the IHDT, and should therefore be monitored as an element of performance.

V. Key Factors Influencing Success

While a multitude of external key factors could influence the Agency s ability to accomplish these Strategic Objectives, the following six factors will probably represent the most significant determinants of success over the next three years.

Per Capita Funding

Since its inception, the IHS has demonstrated the ability to effectively utilize available resources to improve the health status of the American Indian and Alaska Native people including dramatic improvements in mortality rates between 1972 and 1993, including:

- infant mortality reduced 54%
- Years Potential Life increased 54%
- overall mortality reduced 42%
- maternal mortality reduced 65%
- gastrointestinal disease mortality reduced 75%
- TB mortality rate decreased 80%

While funding for the IHS grew considerably through much of its history, per capita funding for the health care of the American Indian and Alaska Native people has never surpassed one half the annual health expenditures of that of the general US population. It is discouraging that despite acheiving significant results, funding has been even less favorable in recent years. Since FY 1992, the IHS has had to absorb $323 million in unfunded fixed cost increases (inflation) which have resulted in almost a 20 percent reduction in constant dollar per capita funding for health services. During this

same time period, and particularly since FY 1993, there has been a significant transition to tribal management of health programs under Title I and III of the Self-Determination legislation. This pattern, and the accompanying decentralization of many functions, has resulted in a loss of economies of scale, particularly for the public health infrastructure. It is also worth noting that this decentralizing trend is in the opposite direction of trends in the health care industry for most of the country. Thus, it is critical for Congress, OMB, and the DHHS to realize that the transition to increased tribal management does require more resources, particularly in the short-term, but is essential for the Self-Determination process, local capability development, and local program effectiveness in the long-term.

If the IHS is to accomplish its Strategic Objectives, it is essential that per capita funding for health services be stabilized, if not increased, as well as increasing support for Self-Determination. Of greatest concern, if the per capita funding continues to decrease, it is likely that access to health services will be decreased and ultimately the health status of American Indian and Alaska Native people will decline. Preliminary evidence support that declines in health services are already occurring.

Reauthorization of the Indian Health Care Improvement Act

The original legislation which was passed in 1976 has served as a foundation for much of the progress in health status for American Indian and Alaska Native people over the last two decades. The reauthorization of this act could potentially do much to bolster the eroding public health infrastructure and restore and expand essential health services to the growing population. The IHS role in the reauthorization process is limited by statute to providing information to Congress and interested parties. Tribal and urban involvement in this endeavor, however, are less constrained and it is critical that the IHS serve its legal advocacy role to assure that their needs and vision are incorporated into the deliberations. Without a strong and well considered Indian Health Care Improvement Act in place to set the tone and mark the future course for decisions regarding budget and health priorities, the future of Indian health care programs could be adversely affected**.**

Third Party Collections

The IHS has developed a Business Plan (Appendix A) as part of the strategy designed to deal with change and meet financial challenges in coming years. Pragmatic business practices are one ingredient to assure that Indians health programs remain solvent. The IHS Business Plan has recognized the opportunity of enhancing available program resources through improved mechanisms of securing eligible third party reimbursements. Under this plan, improving third party collections has become a major emphasis for all I/T/Us, however, changes in policy at HCFA or at the state level can dramatically influence the IHS' ability to gain these critically needed resources.

Reorganization and Improved Technologies

Clearly, opportunities exist for increased efficiency through reorganization and streamlining which was a major goal of the IHDT reorganization plan. The degree to which this goal is realized will likely be determined by both the functional quality of the reorganization plan (i.e., is it rational, efficient and effective given the Agency s responsibilities) and the counterbalancing levels of buy-in and resistance that all affected stakeholders carry into the change process.

Two related strategies of the IHDT plan offer significant potential for enhancing the Agency s efficiency and effectiveness. First, a major strategy of our reorganization is to increase economies of scale through enhanced collaboration across disciplines within the Agency. The second relates to increasing the number of mutually beneficial collaborative working relationships with other Federal, state, local, and private organizations.

While it is too early to assess the effectiveness of our reorganization plan, we have been proactively attempting to address the issue of the acceptability (i.e., buy-in) of our reorganization plan with our staff. Four IHS staff have been trained to facilitate Dr. William Bridges "Transition Management" approach to enhance staff s coping capacity to the emotional stresses of downsizing and reorganization. The IHS has provided this experiential training to several components of the Agency and intends to continue making this training available to staff. Addressing the human side of change is not a luxury, but an investment that will profoundly contribute to the Agency s success. Additional training to assist staff work more effectively in multi -disciplinary teams will become increasingly important in accomplishing more with less. On going training resource support from the Department will be critical to the IHS success with transitions.

Finally, improvements in technology and/or improvements in the implementation of existing technology is likely to profoundly affect the realization of the IHS Strategic Objectives. It is increasingly evident that expansion in the use of information technology has the potential to allow the IHS to do more with less at all levels of the organization. Equally significant benefits may be secured by technologic improvements in the treatment and prevention of diseases. Such improvements in consumer services have already been demonstrated through applied research in IHS and tribal clinics in collaboration with several research institutions, and the potential for even more collaboration is very real. For instance, the impact of a break-through technology in preventing or controlling diabetes could be staggering, both economically and in terms of reducing human suffering.

Transitions to Tribal Management and Managed Care

Both the rate of transition to tribal management of health care and the more global transition of the country s health care systems to the multitude of managed care models is likely to influence the Agency s ability to achieve its objectives. However, it is difficult to forecast in which direction and how these changes could influence "results."

On one hand, it is possible that a rapid continued transfer of control and resources to tribes (without adequate transition funding) could seriously fragment the Agency s already diminished public health infrastructure and result in reduced services and support to remaining direct care tribes, and in the

Agency s inability to meet inherent federal functions including the GPRA. From another perspective, the transfer of resources and management control to tribes could free them to innovate, develop alternative resources, find new mechanisms for building facilities, enhance patient care, and ultimately improve outcomes. Perhaps the most likely result may be that elements of both of these scenarios will be occurring simultaneously and the issue of balancing priorities will become extremely sensitive as discussed later in this section.

The long-term effects of the country s diverse health care reforms, particularly at the state level, and the rapid emergence of managed care models is even more difficult to assess. How well the IHS and tribes interface with these changes, maximize opportunities, and overcome obstacles will undoubtedly be pivotal to success in securing access to services and improving health outcomes.

Regulations and Requirements

With the significant reduction in IHS staff at the Area and Headquarters level (in excess of 60% in some settings), demands on staff have frequently become overwhelming. While the intent of the Reinventing Government initiatives and the National Performance Review (NPR), including the GPRA, were to reduce red tape and government process, increase flexibility, and allow programs to focus on customers and results, the experience of most IHS staff is that the much anticipated reduction in low value "process" has not occurred. To the contrary, new reporting demands of the CFO, GMRA, ITMRA and growing list of requirements attached to the GPRA have actually increased demands for process and often with considerable redundancy. On top of these demands, a considerable number of meetings and/or reporting requirements that often surface with little lead time with the inference that they are "urgent" and/or "important," have frequently turned out to be arguably neither, but take away from significantly reduced staff s ability to serve the customer and focus on results. If this trend continues, the goal of both the NPR and GPRA can be compromised because of the disconnect between the intent and rhetoric and what staff actually experience.

Another area where existing regulations and requirements could be more flexible and user friendly is personnel management. The IHS continues to struggle with recruitment and retention at field sites because of limitations in the available personnel systems. In addition, these same systems and regulations have made downsizing difficult. Current incentives make the use of the "natural attrition" approach to reach downsizing targets the easiest in the short run, but can leave deficiencies in critical functions in the long run. The realization of all of our objectives would be more likely with improvements in existing personnel systems or the creation of new systems which would better address the recruitment, hiring, development and support, and retention of highly capable and committed employees, and fair and effective mechanisms for removing those who do not perform. The Department s "Quality of Work Life" initiative appears to offer potential benefits relative to some of these issues.

The IHS supports the process and intent of the GPRA as a means to achieving success. It is based on the same fundamental principles that have underpinned the public health approach we have used

for over 40 years and has resulted in significant improvements in the health status of American Indian and Alaska Native people. However, it is also evident that success in achieving our Strategic Objectives is also dependent on cooperative efforts with Congress, the Department, OMB, and others in reducing the bureaucratic burdens the IHS is facing, revising conflicting laws, and enhancing flexibility and opportunities to follow our **Guiding Principles** and devote maximal energy towards our **Mission, Goal,** and **Foundation.**

Finding Balance Under a Multitude of Demands

Even if trends in the factors identified above are relatively favorable to the IHS, a major challenge the Agency will continually be facing is the delicate task of balancing priorities, particularly when priorities are sometimes in conflict with each other. With reductions in the public health and administrative infrastructure, balancing legitimate needs and demands from the following incomplete list of priorities will become an increasingly difficult task:

- focusing on preventing diseases
- focusing on treating existing diseases
- investing in research, planning and evaluation
- investing in staff development and empowerment
- investing in services to consumers
- supporting and enhancing alternative methods of developing needed infrastructure
- investing in the infrastructure needed to provide high quality efficient services
- supporting and enhancing direct care programs
- supporting and enhancing tribal and urban programs
- being responsive to the needs and concerns Congress, the DHHS, OMB, etc.
- being responsive to the needs and concerns of IHS staff
- being responsive to the needs and concerns of Indian people

While these are by no means mutually exclusive priorities, they are critical elements of program success that are strongly influenced by science and technology, management, and politics. All of these factors must be carefully balanced through continuous dialog with all stakeholders, but particularly with the American Indian and Alaska Native people we serve. Clearly our ability to facilitate this dialog and to achieve the best possible balance will be a large determinant of our success well into the next century.

VI. Program Evaluation

Throughout its existence, the IHS has utilized a variety of evaluation approaches to assess the structure, process, and outcome of the health care it provides. Relative to structure and process, the IHS has used the accreditation of facilities as one important benchmark. Since 1996, all hospital and eligible clinics have been accredited by the Joint Commission on Accreditation of Healthcare

Organizations. Furthermore, since 1990 six of nine Regional Treatment Centers have been accredited, and the remaining three are preparing for accreditation. The IHS remains committed to maintaining this level of excellence in the future.

A major step in the strategic planning and management process is the evaluation of current results and the measurement of agency performance. In assessing IHS strategic plan performance, Agency-wide, an evaluation process continues to evolve that enables the IHS to monitor and take corrective action throughout the strategic planning cycle. Analysis of test results of the IHS strategic planning model confirmed that summary level resource and outcome data could be linked to strategic objectives on an Area and national basis but that disaggregation of data to sub-Area unit levels could not establish reliable linkages to strategic objectives. A brief discussion of existing data systems used by the IHS to evaluate effectiveness is germane.

The Indian Health Service (IHS) utilizes outside (non-IHS) and IHS data sources to manage and evaluate its diverse programs and assess health outcomes. The two principal outside data sources are the Bureau of the Census and the Centers for Disease Control and Prevention, in particular, the National Center for Health Statistics (NCHS). The Census Bureau is the source of Indian population counts and social and economic data. However, reliable Indian census data at the county level are only available from the decennial census, every 10 years.
The NCHS provides IHS with natality and mortality files that contain all births and deaths for U.S. residents, including those identified as American Indian or Alaska Native. There is miscoding of Indian race on death certificates which understates Indian mortality especially in areas not associated with Indian reservations. While the IHS has developed some techniques for adjusting for miscoding the chief limitations of mortality data are associated with time lags, i.e., the data are not typically available from NCHS until three years after the events occur. This delay in receiving mortality data limits its usefulness in assessing the impact of health interventions. Due to these constraints, IHS has chosen not to use mortality data for annual performance plan indicators except in special circumstances, but will continue to use mortality data for tracking long-term trends in Indian health status and to make comparisons with other population groups.

The IHS also continuously evaluates its programs with its own program information systems that collect data on the services provided by IHS and tribal direct and contract programs. The software used by IHS facilities and most tribal facilities is the Resource and Patient Management System (RPMS). Data are collected for each inpatient discharge, ambulatory medical visit, and dental visit (all patient specific) and for community health service programs including health education, community health representatives, environmental health, nutrition, public health nursing, mental health and social services, and substance abuse (all activities reporting systems). The patient-specific data are collected through the Patient Care Component (PCC) of the RPMS.

Each facility that utilizes PCC has a facility-level database that contains the detailed PCC data collected at that site. A subset of the detailed PCC data (to meet the routine information needs of IHS Headquarters) is transmitted to the IHS central database. PCC data are the source of most of IHS GPRA measures since they reflect prevention activities and morbidity and do not have the time

lags described above for mortality data. However, many of IHS proposed measures for the GPRA will rely on detailed PCC data not currently transmitted to the IHS central database. IHS is developing software to transmit some of these needed data items to the central database. In the meantime, IHS will need to use sampling routines to collect the required data from the individual facility-level databases. In some cases, the required data for a measure may not be part of PCC or, if it is, may not be coded at some facilities. Local surveys may need to be utilized in these areas to capture the required data. The degree to which these activities will be achieved is linked to available infrastructure to address these demands, which in turn is determined by budgets and the many competing priorities.

The IHS program information systems collect data only for persons accessing the IHS-sponsored health care system. Since these data are not population based, true prevalence and incidence rates cannot be calculated. The data can be used to approximate these rates, in other words, good proxy prevalence and incidence rates can be calculated from the IHS program databases. IHS would like to be able to use the population-based results of national health surveys, such as the National Health Interview Survey conducted annually by NCHS. This is not possible now since national health surveys are not designed to properly sample AI/AN people to produce statistically-reliable results. The IHS is currently working with the Department of Health and Human Services and NCHS to develop a long-term strategy that will at least periodically provide reliable information for targeted Indian groups.

The IHS and tribes are moving into a new information systems environment. This is caused by: a) the tribal takeover of the program and the associated tribal option on whether or not to report the same program data into the IHS central database as IHS providers report, b) new reporting requirements being prescribed by other federal agencies, e.g., the Health Care Financing Administration, States, etc., and c) changing information technologies. The IHS and the tribes plan to develop new information systems strategies and policies. Specifically , the IHS is engaged in a study to developed automated cost accounting capability in concert with health services and health status information. Therefore, the current IHS information structure and network will change significantly in the next five years. This change will probably require adjustments, hopefully improvements, to the way the GPRA measures are calculated.

At the present time, the best single compilation of the program data and health status assessments thus far discussed in this strategic plan is published each year in two documents: ***Trend*s *in Indian Health*** (Appendix B) and ***Regional Differences in Indian Health*** (Appendix C). The ***Trends*** publication presents information on trends in Indian health status (1972-present for mortality data and 1955 to present for patient care data) for IHS in the aggregation in comparison to the U.S. general population. The companion document, ***Regional Differences***, shows the current state of Indian Health status by region/Area in comparison to the IHS aggregate and the U.S. general population.

A final evaluation process utilized by the IHS is the annual research and evaluation (R & E) cycle which is an annual call for proposals covering all health program evaluation, policy analysis, and

health services research. This cycle follows the Department's policies on evaluation and is annually submitted first as a plan and at the conclusion of the cycle as a report. The goal of the IHS R & E cycle is to support the strategic plan and provide IHS policy makers, AI/AN tribes and organizations, and DHHS and other Federal agencies with valid and reliable information to improve programs, to determine their effectiveness, support budget requests, and to implement long range plans.

Since tribes play such an integral part in the IHS programs, accurate evaluations must depend upon their involvement. With this in mind, the IHS encourages not only conventional evaluation approaches, but has also adopted and implemented a responsive-naturalistic method of evaluation (fourth generation). The IHS attempts to incorporate the claims, concerns, values, and issues of all stakeholders. Depending upon the evaluation being conducted, stakeholders can include IHS program staff, tribes and other Indian communities, DHHS staff, other federal agency staff, etc. Assessments are made not only through data analysis, but through negotiation and collaboration. In this way, social and political issues which affect the Indian community receive consideration. More specifically, responsive evaluation moves beyond mere science-just getting the facts-to include the myriad human, political, social, cultural, and contextual elements that are involved; with the key dynamic being negotiation.

Evaluation is a continuous process, and one needs to monitor the program at all stages of its process. The shared control of the evaluation process (IHS, tribe, and evaluator) allows a sharing of roles which leads to a clearer perception of the overall health situation. Human nature dictates that people will work more diligently toward success if they have their own interests at stake. The IHS has successfully assisted a number of Areas and tribes using the responsive evaluation principles. Evaluation results are disseminated through IHS evaluation briefing books, briefings held for IHS staff on results of studies, use of symposia and through periodic briefings held at Area Offices.

The IHS evaluation methodology institutes such continuity and shared control with a cyclical process. IHS Area and Associate Directors are asked through an annual call for proposals to provide possible areas for evaluation study. These proposals are reviewed and rated by a panel of subject matter experts and evaluation experts and reviewed by IHS staff for more specific concurrence with IHS annual objectives, long range goals, areas of emphasis, etc. Proposals are then prioritized and forwarded to the IHS planning and evaluation officer and then to the Director, IHS, for final review and approval. An analysis of the evaluation results reveals patterns and improvements used to incorporate a policy analysis approach. Questions guiding the evaluative process would be: What parts of the program led to the improvements? Where can adjustments be made to better the results in the future? How do tribes view these programs? Do the tribes believe changes are necessary? The initial results and the answers to such questions bridge evaluation and policy and create the policy issues. Then, the evaluation cycle begins again.

Although most of the studies that IHS conducts are qualitative in scope using existing databases of specific program components, there are studies, which IHS realizes are necessary and more

appropriate in answering questions related to budget and planning, that are more quantitative in nature.

In summary, the Agency's approach to evaluation planning makes use of evaluation theory including proven principles of stakeholder involvement and negotiation. This evaluation planning approach is consistent with and supports the IHS Strategic Plan and the Annual Performance Plan.